



Where Entry Level Employment
Is Just A Beginning™

Ability In Motion Inc.

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

Linda B. Moriber, M.A., C.R.C.
President & COO

State of Connecticut
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS # 12 HSR
P.O. Box 340308
Hartford, CT. 06134

Attn: Susan Coles

July 2, 2004

Dear Susan,

Enclosed please find our letter of intent form 2030 application to pursue a licensed psychiatric outpatient clinic for adults in the greater Bridgeport area.

Please contact me if you have any questions.

Sincerely,

Linda Moriber, M.A., C.R.C.
President and Chief Operating Officer



State of Connecticut Office of Health Care Access Letter of Intent/Waiver Form Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Ability In Motion	
Doing Business As	Ability In Motion	
Name of Parent Corporation	N/A	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	4749 Main Street Bridgeport, CT. 06606	
Applicant type (e.g., profit/non-profit)	Profit	
Contact person, including title or position	Linda Moriber, M.A., C.R.C. President & COO	
Contact person's street mailing address	4749 Main Street Bridgeport, CT. 06606	
Contact person's phone #, fax # and e-mail address	1-203-372-6246 fax # (203) 372 - 2910 e-mail- lmoriber@aim-ne.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: Outpatient Mental Health Facility

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, S, Fnc)

☐ Replacement

☒ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc)

☐ Relocation

☐ Service Termination

☐ Bed Addition

☐ Bed Reduction

☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost greater than \$ 1,000,000

☐ Equipment Acquisition greater than \$ 400,000

☐ New

☐ Replacement

☐ Major Medical

☐ Imaging

☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$1,000,000

c. Location of proposal (Town including street address):

4749 Main Street, Bridgeport, Connecticut 06606

d. List all the municipalities this project is intended to serve:

West Haven, Orange, Milford, Stratford, Bridgeport, Fairfield, Norwalk,
Stamford, Greenwich

e. Estimated starting date for the project: 8/1/04

- f. Type of project: ¹⁸_____ (Fill in the appropriate number(s) from page 7 of this form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
n/a				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Capital Expenditure:
- b. Please provide the following breakdown as appropriate:

Construction/Renovations	
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	\$0.00
Fair Market Value of Leased Equipment	
Total Capital Cost	\$0.00

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
n/a				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

- ☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan
☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding
☐ Funded Depreciation ☐ Other (specify):

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

AIM-ABILITY IN MOTION

SECTION IV. PROJECT DESCRIPTION

- 1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.**

Ability In Motion, Inc., (AIM) is a for-profit community-based rehabilitation business, serving individuals with disabilities throughout the New York and Connecticut tri-state area.

AIM was developed specifically to focus on the needs of person with disabilities. Since its' inception three years ago, AIM has served over 1,000 individuals in its' New York City, Connecticut, and Westchester programs. The thrust of Aim's program is to provide vocational rehabilitation which includes, but not limited to, job development, job coaching, situational assessments, resume development and career counseling to individuals with a variety of disabilities. Our consumers are being served exclusively in the community, all of which have their foundations in the supported employment model. The staff is comprised of experienced job coaches and developers. Each member of the supervisory staff has a master's degree in either human services or counseling. In Connecticut, AIM currently serves people referred by the Department of Social Services, Bureau of Rehabilitation Services, the Department of Board of Education, the Trumbull Board of Education, the Monroe Board of Education, the Veteran Administration, and some private entities.

- 2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?**

The types of services that are being proposed is a mental health outpatient clinic. This clinic will provide psychological evaluations, individual, family and group counseling and behavioral health modification services.

- 3. Who is the current population served and who is the target population to be served?**

The current population served in our existing programs are mental retardation, learning disability, psychiatric, acquired brain injury, asberger syndrome, autism and visual and hearing impairments. Many of these individuals are receiving vocational and employment training services. The targeted population to be served is the cognitive and physical disabilities with concurrent psychological problems. These psychological disabilities can include depression, anxiety, adjustment disorders, developmental disorder etc.

4. Identify any unmet need and how this project will fulfill that need.

If the individuals do not suffer from severe mental illness or drug abuse there is a need for services for many different psychological disorder. In fact, many of the DSS workers state that the only place individuals can receive psychological testing are at hospitals for special care. This is often impossible because of the transportation difficulty. This project will fulfill the needs for services in the greater Bridgeport area.

5. Are there any similar existing service providers in the proposed geographic area.

No.

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

This project will provide access for people with psychological or mental disorders in the greater Bridgeport area. The only population that is currently being served and have title 19 are the individuals with severe mental illness and substance abuse problems.

7. Who will be responsible for providing the service?

Licensed Clinical Psychologist

8. Who are the payers of this service?

The primary payers of this service will be Medicaid, Medicare and Private Insurance companies

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following:
(Please check all that apply)

This request is for Replacement Equipment.

The original equipment was authorized by the Commission/OHCA in Docket
Number: _____.

The cost of the equipment is not to exceed \$2,000,000.

The cost of the replacement equipment does not exceed the original cost
increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: Ability In Motion

Project Title: Outpatient Mental Health Facility

I, Linda Moriber, President & Chief Operating Officer
(Name) (Position – CEO or CFO)

of Ability In Motion being duly sworn, depose and state that the

information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to

the best of my knowledge, and that Ability In Motion complies with the appropriate and
(Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486
and/or 4-181 of the Connecticut General Statutes.

Linda B Moriber
Signature

6/29/04
Date

Subscribed and sworn to before me on 6-29-2004

[Signature]
Notary Public/Commissioner of Superior Court

My commission expires: 7-31-2004